PATIENT DEMOGRAPHICS

NAME: _______________________________________DOB______/__________/_______ SEX M F

ADDRESS: ____APT__________________________

CITY: ____STATE______________ZIP____________________

CELL PHONE: _________________________________ HOME PHONE: ___________________________

SOCIAL SECURITY NUMBER: ______-_____-______ MARITAL STATUS: M S D W WORK STATUS: FT PT RET U DIS

EMPLOYER: _______________________________________ WORK PHONE: ____________________________

EMERGENCY CONTACT: _________________________ PHONE: ___________________________________

PHYSICIAN REFERRING: ____________________________________ FAMILY PHYSICIAN____________________

MEDICATION ALLERGIES: ____

LATEX ALLERGY: YES NO

IS TODAYS PROBLEM RELATED TO AN ACCIDENT OR INJURY: YES NO
Type of accident:____

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INSURANCE INFORMATION

PRIMARY INSURANCE: __________________________________NAME OF INSURED: _________________________
Relationship to Patient: _____________________Date of Birth: _______________ SSN: _______________________
Policy holder address if different from patient: ____
Policy holder employer: ____

SECONDARY INSURANCE: __________________________________NAME OF INSURED: ______________________
Relationship to Patient: _____________________Date of Birth: ________________ SSN: _______________________
Policy holder address if different from patient: ____
Policy holder employer: ____

I hereby authorize payments from my insurance company to the physician for the medical services provided. I understand I am responsible for any portion of my bill not covered by my insurance. I hereby authorize release of information for insurance claim purposes. Copies of the above are as valid as the original. I understand the above and hereby state the information I have supplied is correct to the best of my knowledge.

Signature of patient (or insured if patient is a minor) ____________________________________*Date*_____________

Note: We do not file for Motor Vehicle Accidents if date of accident is more than 6 months.